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[Nov 01, 2023 Today Updated NCLEX-PN Exam Dumps Actual Questions [Q405-Q424

[Nov 01, 2023] Today Updated NCLEX-PN Exam Dumps Actual Questions
NCLEX-PN exam dumps with real NCLEX questions and answers

NCLEX-PN exam is developed and maintained by the National Council of State Boards of Nursing (NCSBN). This organization is responsible for ensuring that the exam is up-to-date and relevant to the current nursing practice. NCLEX-PN exam is computerized and consists of multiple-choice questions that are designed to test the individual's understanding of nursing concepts, patient care, and nursing procedures.

QUESTION 405

The primary organ for drug elimination is the:
* skin.
* lung(s).
* kidney(s).
* liver.

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Most drugs are excreted in the urine, either as the parent compound or as drug metabolites. Relatively few drugs are excreted in sweat. Some volatile gases are excreted with expiration. The liver primarily metabolizes drugs. Some of them are excreted in bile, especially those with a molecular weight above 300.PharmacologicalTherapies

QUESTION 406

Which of the following is the primary force in sex education in a child’s life?
* school nurse
* peers
* parents
* media

Section: Health Promotion and Maintenance

Explanation:

Parents are the primary force in sex education in a child’s life.

The school nurse is involved with formal sex education and counseling.

Peers become more important in sex education during adolescence but might lack correct information.

The media play a powerful role in what children learn about sex through movies, TV, and video games.

QUESTION 407

Which of the following statements, if made by the parents of a newborn, does not indicate a need for further teaching about cord care?
* “I should put alcohol on my baby’s cord 3-4 times a day.”
* “I should put the baby’s diaper on so that it covers the cord.”
* “I should call the physician if the cord becomes dark.”
* “I should wash my hands before and after I take care of the cord.”

Explanation/Reference:

Explanation:

Parents should be taught to wash their hands before and after providing cord care. This prevents transferring pathogens to and from the cord. Folding the diaper below the cord exposes the cord to air and allows for drying.

It also prevents wet or soiled diapers from coming into contact with the cord. Current recommendations include cleaning the area around the cord 3-4 times a day with a cotton swab but do not include putting alcohol or other antimicrobials on the cord. It is normal for the cord to turn dark as it dries. Health Promotion and Maintenance

QUESTION 408

The acts enacted by states to provide immunity from liability to persons who provide emergency care at an accident scene are called:
* Good Samaritan laws.
* HIPAA.
* Patient Self-Determination Act (PSDA).
* OBRA.

The Good Samaritan laws protect providers of care in an emergency situation. HIPAA’s focus is confidentiality of

information and right to privacy. The PSDA concerns a client’s autonomous decision-making. OBRA was passed in the late 1980s to promote nursing home reform due to quality issues.Coordinated Care

QUESTION 409

How often should the nurse change the intravenous tubing on total parenteral nutrition solutions?
* every 24 hours
* every 36 hours
* every 48 hours
* every 72 hours
Explanation/Reference:

Explanation:

The nurse should change the intravenous tubing on total parenteral nutrition solutions every 24 hours, due to the high risk of bacterial growth. Health Promotion and Maintenance

QUESTION 410

Which intervention should the nurse take first to assist a woman who states that she feels

incompetent as the mother of a teenage daughter?
* Recommend that she discipline her daughter more strictly and consistently.
* Make a list of things her husband can do to help her improve.
* Assist the mother to identify what she believes is preventing her success and what she can do to improve.
* Explore with the mother what the daughter can do to improve her behavior.
The intervention priority with a mother who feels incompetent to parent a teenage daughter is to assist the mother to identify what she feels her crisis events are and to help her develop better coping skills and improve her mothering skills. With a teenager, the growth and development parameters have to be concentrated on self as well as acquiring an added event. Choices 1, 2, and 4 do not directly address the mother’s feelings of inadequacy.Psychosocial Integrity

QUESTION 411

A client newly diagnosed with Diabetes Mellitus needs education. Which of the following statements should the nurse include in this education?
* “You can eat anything you want, but no foods with sugar.”
* “You need to lose weight, so your diet must be a restricted one.”
* “You need a diet and exercise program.”
* “You must eliminate all salt, fat, and sugar from your diet.”
Explanation/Reference:

Explanation:

A client newly diagnosed with Diabetes Mellitus needs teaching about diet and exercise. Physiological Adaptation

QUESTION 412

When caring for a client with a possible diagnosis of placenta previa, which of the following admission procedures should the nurse omit?
* perineal shave

* enema
* urine specimen collection
* blood specimen collection
An enema could dislodge the placenta and increase bleeding.Physiological Adaptation

QUESTION 413

One day postoperative, the client complains of dyspnea, and his respiratory rate (RR) is 35, slightly labored, and there are no breath sounds in the lower-right base. The nurse should suspect:
* cor pulmonale.
* atelectasis.
* pulmonary embolus.
* cardiac tamponade.
Explanation/Reference:

Explanation:

The first three symptoms could be indicative of any of the conditions. The distinguishing symptom is the lack of breath sounds in the lower-right base, which is assessed when a portion of the lung has collapsed.

Physiological Adaptation

QUESTION 414

Which of these types of fluid output is not typically measured?
* emesis
* urine
* chest tube drainage
* evaporative water from the respiratory tract
Section: Physiological Integrity

QUESTION 415

Which of the following assessment tools is used to determine the patients’ level of consciousness?
* the Snellen Scale
* the Norton Scale
* the Morse Scale
* the Glasgow Scale
Section: Health Promotion and Maintenance

Explanation:

The Glasgow Scale assesses for altered levels of consciousness.

The Snellen chart, not scale, is used to assess and measure visual acuity; the Norton Scale assesses patients’ risk for skin breakdown; the Morse Scale assesses patients’ risk for falls.

QUESTION 416

The nurse uses prioritization to determine all the following except:

* time allotment for certain tasks.
* appropriate interventions.
* treatment procedures.
* the need for client education.
Explanation/Reference:

Explanation:

Treatment procedures are standards of care as defined by the facility or nursing unit. If a treatment is indicated, the nurse is obligated to follow the established procedure to be compliant with practice standards. Established priorities contribute to the determination of time management, appropriate interventions, and the need for client education as a potential intervention. Coordinated Care

QUESTION 417

A two-year old has been in the hospital for 3 weeks and seldom seen family members due to isolation precautions.

Which of the following hospitalization changes is most like to be occurring?
* Guilt
* Trust
* Separation anxiety
* Shame
Section: Psychosocial Integrity

Explanation:

Separation anxiety can easily occur after six months during hospitalization.

QUESTION 418

A patient has a history of cardiac arrhythmia. A nurse has been ordered to give 2 units of blood to this patient. The nurse should take which of the following actions?
* Prep the patient with pain medication.
* Notify the patient’s family about the procedure via the telephone.
* Decrease the temperature of the blood to be given.
* Increase the temperature of the blood to be given.
Explanation/Reference:

Explanation:

Warming the blood will reduce the risk of additional cardiac arrhythmia.

QUESTION 419

A nurse is reviewing a patient’s current Lithium levels.

Which of the following values is outside the therapeutic range?
* 1.0 mEq/L
* 1.1 mEq/L
* 1.2 mEq/L
* 1.3 mEq/L

Section: Physiological Integrity

Explanation:

1.0-1.2 mEq/L is considered standard therapeutic range for patient care.

QUESTION 420

All of the following are causes of vaginal bleeding in late pregnancy except:
* placenta previa.
* eclampsia.
* abruptio placentae.
* uterine rupture.
Explanation/Reference:

Explanation:

Eclampsia is a disorder of pregnancy characterized by hypertension, proteinuria, and edema. This condition can cause seizure and/or coma. Choices 1 and 3 are abnormal conditions that can cause bleeding, particularly in the third trimester. Choice 4 is a major obstetrical emergency that can cause bleeding internally and externally. Safety and Infection Control

QUESTION 421

A nurse is performing a screening on a patient that has been casted recently on the left lower extremity. Which of the following statements should the nurse be most concerned about?
* The patient reports, “I didn’t keep my extremity elevated like the doctor asked me to.”
* The patient reports, “I have been having pain in my left calf.”
* The patient reports, “My left leg has really been itching.”
* The patient reports, “The arthritis in my wrists is flaring up, when I put weight on my crutches.”
Pain may be indicating neurovascular complication.

QUESTION 422

While repositioning a comatose client, the nurse senses a tingling sensation as she lowers the bed. What action should she take?
* Unplug the bed’s power source.
* Remove the client from the bed immediately.
* Notify the biomedical department at once.
* Turn off the oxygen.
Shutting off the bed’s electricity should be the initial step. The nurse should not touch the client until the bed is checked for faulty grounding. An electrician should assess the equipment. Oxygen should be discontinued until the equipment is cleared.Safety and Infection Control

QUESTION 423

Mrs. Owens is the 81-year-old mother of Jonathan, who is 54 years old. Jonathan has had schizophrenia since he was 16 years old. Which of Mrs. Owens’s concerns is likely to

predominate?
* “Will my retirement funds outlast me?”
* “Who will handle my funeral arrangements?”

* “What will become of Jonathan when I am gone?”
* “How can I get Jonathan’s physician to talk to me?”

The mother’s most prominent concern is likely to be what becomes of her son after she dies. Choice 1 is important but is not likely to be her most prominent concern. Choice 2 is also not likely to be her primary concern because the welfare of her son with schizophrenia is more important. Choice 4 is incorrect because Mrs. Owens has likely confronted and handled concerns about getting the physician to talk to her after 38 years of managing her son’s care. Psychosocial Integrity

QUESTION 424

Which of the following observations is most important when assessing a client’s breathing?
* presence of breathing and pulse rate
* breathing pattern and adequacy of breathing
* presence of breathing and adequacy of breathing
* patient position and adequacy of breathing

Explanation/Reference:

Explanation:

It is not enough to simply make sure the client is breathing. The client must be breathing adequately.

Physiological Adaptation

NCLEX-PN exam is comprised of multiple-choice questions that cover a wide range of nursing topics. These topics include basic nursing concepts, patient care, pharmacology, and nursing procedures. NCLEX-PN exam also includes questions that test critical thinking and problem-solving skills, as well as questions that assess the candidate's ability to prioritize patient care.

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